Careful selection of the FHS is important. Time must be spent talking to the woman herself, the FHWs and members of the community, to establish her character, her experience and her acceptability to the people.

On occasions the choice of FHS is immediately apparent. This woman is usually the traditional Dai from Afghanistan, and when found she will often help to motivate women for training. Her wealth of experience and position within the community makes her a valuable asset to the programme.

The recommended criteria for selection of FHS are as follows.

- She should be an experienced Dai, and resident in the refugee village.
- She should be aged between 30 - 45 years and able to travel in the refugee village.
- If she is too young, she will not be mobile or respected. If she is too old, she will not be active.
- She must be a respected member of the community, acceptable to the elders, her groups of FHWs and the BHU staff.
- She must be prepared to work in the BHU 2 days a week, and to visit the FHWs and their extended families in the refugee village.
- She must be enthusiastic, eager to learn and to pass on her knowledge to others.

8. TRAINING OF FHSs AND FHWs

8.i TRAINING GROUPS

The number of women trained in one group should be a minimum of four, and a maximum of twelve. Too small a group restricts teaching methods such as role plays and group work. It is also uneconomical in terms of staff. Too large a group means the trainer has less time to spend on individuals, and revision of practical skills are time consuming. The training sessions are usually held in the home of either the CHS, malik, FHS or one of the FHWs. This home must be accessible and acceptable to all women in the group.

8.ii TRAINING SESSIONS

The training courses for FHSs and FHWs consist of 2-hour sessions, 5 days a week for 6-8 weeks. During each session there is a ten minute break, and tea is supplied by the Female Trainer and prepared by the household.

The teaching sessions should not continue for longer than 2 hours, as many of the women have other responsibilities and work to do in their homes. In long sessions the women become restless and demotivated. The length of training must remain flexible, as some groups require more time to absorb the new knowledge. However, if the courses are continued for too long, the women tire and cease to learn. Weak areas should be noted and revised in the Refresher Courses.

The FHS should be encouraged to give extra revision sessions for her groups. If previous groups of FHWs have been trained in the village, these women should be introduced to the new groups if possible. They can motivate the women and help them through sharing their experiences.

Although the size of the groups must be limited, other family members often sit at the back and listen. This is not a problem, as long as they do not disrupt the sessions. Small children may be distracting at times, but usually the women themselves request the children to be controlled.

Some women are frightened at the thought of attending training sessions. The trainer must be sensitive to this and proceed slowly, at a pace the FHWs feel comfortable.

The LHV from the BHU must attend at least one training session every week, to familiarize herself with the FHWs, and to learn the course content. In Afghan culture the teacher is a highly respected person, and by being involved in revision sessions and discussions the LHV will gain the co-operation of the women when supervising their work after training.

8.iii TEACHING METHODS AND AIDS

As the majority of women are illiterate with no previous educational experience, it is essential that the training courses are specially designed for their needs.

The women find it difficult to absorb information given in the "lecture" method. Teaching methods must be varied and practically orientated, to including many role plays, demonstrations and discussions. During training sessions, the trainers are encouraged to use groupwork as a way of involving all the women and maintaining their attention.

Teaching aids must be appropriate to the culture and the situation. The Trainers must understand how to use them effectively. Poems can be used to retain information such as the diseases prevented by vaccination and their dosage schedule. Games and quizzes are popular, but competitions may lead to quarrels and resentment. The Training Team must vary their teaching techniques to keep the FHWs interest and to encourage their participation in the lessons. Regular workshops for Trainers are vital to maintain the standards and expertise required for effective teaching.

(For contents of Teaching Aid Kit see Appendix 5.)
Teaching Aid Kits are available from the SCF office, Peshawar.

8.iv TRAINING MANUAL

The UNHCR Training Manual, which has been compiled in conjunction with the Voluntary Agencies involved in FHW training, is used on this programme.

The topics of the training manual are taught in an order appropriate to the situation. The topics with which the FHWs are most familiar are introduced first, rather than a usual textbook approach. Thus delivery techniques are taught before antenatal care. However if certain topics are relevant to the FHWs current experiences, these will be taught early in the course. For example prevention of malaria during the transmission season, and management of diarrhoea in the hot season.

The additional topics in the Manual are optional and may be selected if appropriate. Promotion of birth spacing is an extremely sensitive topic for the Afghans, and reactions must be carefully investigated before this topic is introduced.

(For topics of the manual - See Appendix 4.)

8.v TRAINING REGISTERS

During the course details of the training, such as attendance of the FHWs, the topic taught each day and any relevant comments, are kept in a Training Register. The details of the final assessment are also recorded. This register is left with the LHV in the BHU for future reference, as a record of the FHWs and their training.

8.vi THE FHW KIT

The FHW kit is given to each FHW early in the training course, once preparation for delivery and delivery technique has been covered. In this way the FHWs become used to the kit, and they can put into practice what they have learnt.

(For contents of kit - See Appendix 6.)
FHW Kits are available from the SCF office, Peshawar.

8.vii ASSESSMENTS

The FHSs and FHWs are continuously assessed during the training sessions, and extra help is given to any women encountering difficulties. At the end of the course, an informal assessment is arranged prior to distribution of the certificates. A final celebration tea party is given afterwards.

Although this assessment is made as informal as possible, the women are often extremely apprehensive. It is explained to them before the assessment that all the women will receive a certificate. There is no question of failure, but the purpose of the assessment is to identify any topics that need revision either now or later, during the Refresher Courses. These women are volunteering their services, and their contribution should not be rejected. Each FHW is asked 4 or 5 questions, including a demonstration of a practical skill.

Although the women are often nervous, the day is seen as an occasion to mark the end of the training, and is enjoyed in retrospect if not always at the time. The LHV from the BHU should attend the assessments, so that the FHWs feel recognised as members of the health team.

9. SUPPORT AND FOLLOW UP

9.i REFRESHER COURSES

Regular refresher courses are held for the FHWs every 6 months. These consist of 2-hour sessions, for 5 days. The topics for each group are decided on the basis of:

- Known areas of weakness.
- Health problems in the refugee village at that time e.g diarrhoea, malaria etc.
- Informal questioning on the first day.

Sometimes women are reluctant to attend these refresher programmes, and it is important to vary teaching methods and to introduce new concepts or topics. It may be preferable to include the additional topics in the UNHCR manual under the Refresher Programme, rather than extending the length of the original training course.

9.ii INCENTIVES

As the FHWs are working voluntarily, it is important to reward their services. Financial reward on an acceptable level to large numbers is not an option due to bugetary constraints. However, the FHWs can be motivated to work in other ways, for example through recognition and appreciation of their work from the BHU staff, the Training Team, and the community. Gifts of material or items of clothing may also be given. Incentives given at Refresher training will have the bonus of attracting women to attend the courses. At present these gifts are given out annually as in the Male CHW programme.

9.iii WORKSHOPS

Integration of the FHW programme as a part of the health services in the refugee villages is essential to achieve the maximum effect of the programme. It is important that the staff of the BHU, especially the MO and the LHV, fully understand the concept of the programme, the roles of the FHSs and FHWs, and how they can assist in the provision of health care. Workshops are held for the LHVs in the BHUs to explain this and to assist with the implementation of the programme. These workshops last 1-3 days and the Deputy Director MCH and the LHV supervisors are involved in planning and running them. The topics covered are:

- Motivation techniques
- Selection procedures.
- Teaching methodologies.
- Roles of FHSs and FHWs.
- Supervision of FHSs and FHWs.
- Integration of the FHW programme.

9.iv SUPERVISION OF ACTIVITIES

The PDH is responsible for the supervision of the trained FHSs' and FHWs' activities. The LHV in the BHU holds monthly meetings with the FHWs in their homes.

At these meetings the LHV:

- collects information on deliveries.
- arranges homevisits to provide postnatal examinations, and to commence immunisation of the newborn.
- resupplies the FHWs with the necessary items for their kits.
- discusses any problems or queries with the FHWs.

These meetings are important to maintain contact with the FHWs, and to motivate them to carry out their work.

The LHV coordinates her home visits with the FHWs, through the FHS. In this way she can cover all areas in the village, and give recognition to the FHWs as part of the health team.

On the days that the FHS attends the BHU she can give health education talks to the women waiting to be seen. The LHV can teach the FHS additional skills, such as abdominal palpation. The FHS should not be used as an extra pair of hands to carry out tasks such as making tea or crowd control.

(For role of FHS see Appendix 1.)

10. EVALUATION OF PROJECT IMPACT

Prior to the introduction of the FHW programme, a survey is performed to collect information on health knowledge and practices in the refugee villages. This may be used as a baseline in future evaluations of the programme.

The Project Manager and Assistant Project Manager monitor training standards during regular visits to the training sessions. Evaluations are made during the assessments on completion of training, and the questionnaires at the beginning of the refresher courses.

The PDH collects data on the activities of the FHSs and FHWs, including the number of deliveries performed.

APPENDIX 1.

ROLE OF THE FEMALE HEALTH SUPERVISOR

The Female Health Supervisor will be based in the community, supervised by the LHV from the BHU. Her role will be to:

1- Carry out the role of FHW within her family group.

2- Assist the BHU LHV in her duties within the community, concerning the FHWs, with combined home visits.

3- Support, advise and assist the FHWs through regular home visits.

4- Assist the FHWs in reporting births and deaths and such data as required to the LHV in the BHU.

5- Assist with the resupply of equipment to the FHWs.

6- Attend the BHU for 2 days every week and assist the BHU LHVs in the Antenatal and Postnatal clinics. The rest of the time to be spent working within the community.

7- Assist in motivation for immunisation and outreach immunisation activities within her extended family group.

8- Follow up antenatal and postnatal referrals and trace defaulters from the BHU LHV.

9- Refer problems and complications beyond her control to the doctor / LHV in the BHU.

10- Assist in improving the health status of all women and children to the best of her ability.

APPENDIX 2.

ROLE OF THE FEMALE HEALTH WORKER

The Female Health Worker will be trained as a teacher of other women within her family kinship group. Her role will be to:

1- Create an awareness and understanding of the importance of antenatal care.

2- Regularly visit the pregnant women in her family group to advise on health care during pregnancy.

3- Encourage the women to be immunised against Tetanus.

4- Carry out new skills learned during training to prevent complications and infections before, during and after delivery.

5- Recognise early signs of complications and refer to the LHV or doctor in the BHU.

6- Manage any complications until referral is possible.

7- Improve care of the mother and baby after delivery and undertake regular home visits to them.

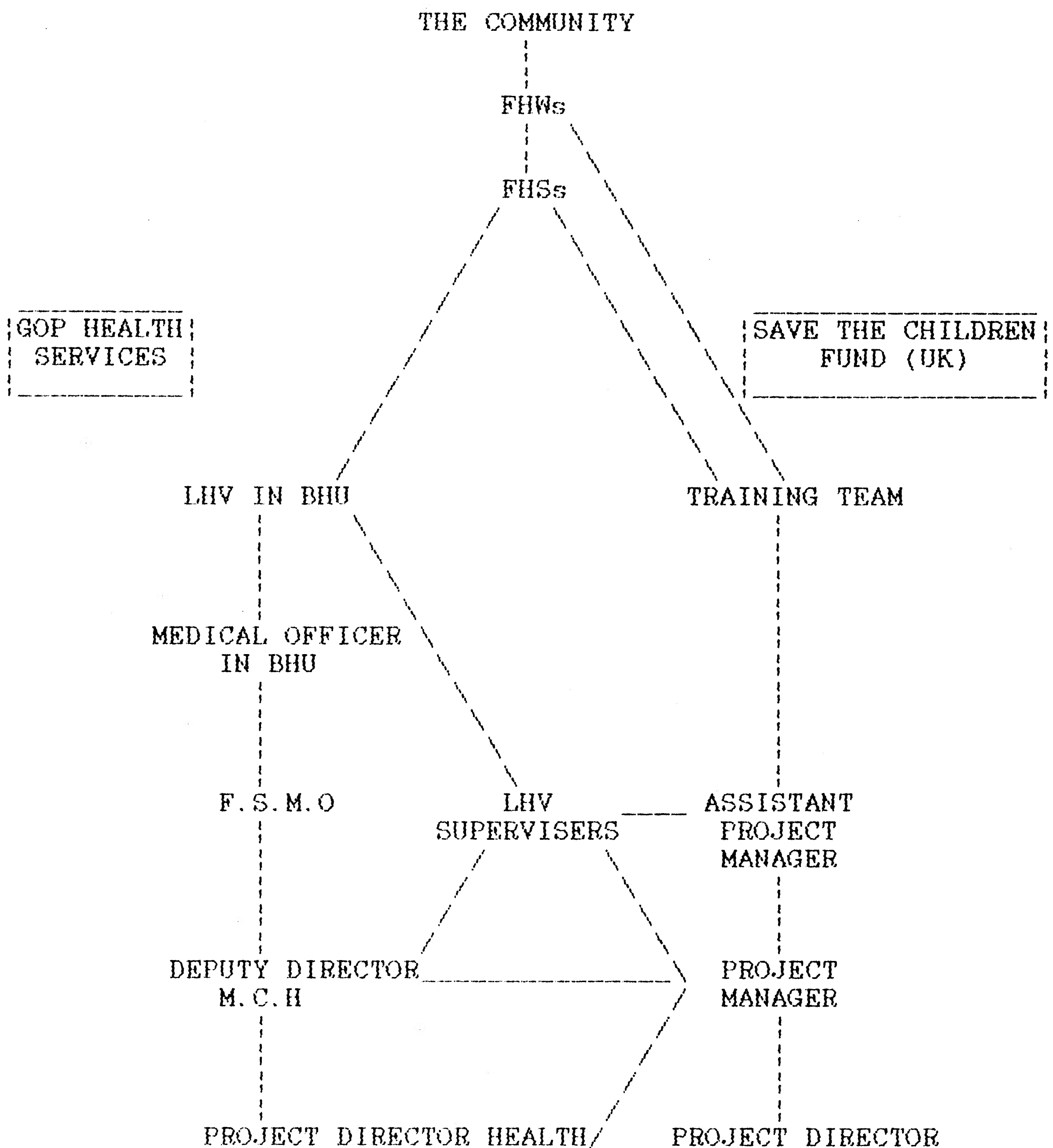
8- Assist in the motivation for vaccination of under fives within her family group.

9- Assist in the improvement of the health status of mothers and children within her family group to the best of her ability.

10- Share her new skills and knowledge whenever possible with other women.

11- Report births and deaths and such data as required to the FHS, or the LHV if she is able to visit the BHU.

APPENDIX 3.


THE COMMUNITY
FHWs
FHSs
GOP HEALTH SERVICES
SAVE THE CHILDREN FUND (UK)
LHV IN BHU
TRAINING TEAM
MEDICAL OFFICER IN BHU
F.S.M.O
LHV SUPERVISERS
ASSISTANT PROJECT MANAGER
DEPUTY DIRECTOR M.C.H
PROJECT MANAGER
PROJECT DIRECTOR HEALTH
PROJECT DIRECTOR

APPENDIX 4.

ESSENTIAL TOPICS:

1. Introductory session
2. Normal pregnancy
3. Microbes and handwashing
4. Tetanus
5. Home visits during pregnancy
6. Danger signs in pregnancy
7. FHW kit, report forms and resupply
8. Normal labour
9. Danger signs in labour
10. Normal delivery
11. Danger signs at delivery
12. Home visit for first few days after delivery
13. Danger signs for first few days after delivery
14. Home visits to children under 2 years
15. Danger signs in children
16. Diarrhoea

ADDITIONAL TOPICS:

1. Birth spacing
2. Household cleanliness
3. Malaria
4. T.B
5. First Aid
6. Helping disabled people
7. Mines awareness

1. INTRODUCTION

Since 1983 Save The Children Fund(UK) (SCF) has been implementing a Primary Health Care programme for Afghan Refugees in North West Frontier Province, Pakistan. This programme trains Male and Female Community Health Workers in the promotion of health and prevention of disease.

The aim of this paper is to provide information on the development of the Female Health Worker programme, and give details of the current methods of implementation. Where relevant, potential problems are noted and suggestions made as to how these can be avoided. It is hoped that this will prove useful to other organisations introducing similar programmes.

2. PRIMARY HEALTH CARE

Major international interest in Primary Health Care began with the WHO/UNICEF conference at Alma Ata in 1978. It was realized that many of the health problems of developing countries could not be overcome by providing conventional curative services alone. Primary Health Care requires an equitable distribution of services, the involvement of the community, a focus on prevention, appropriate technology and a multisectoral approach. This approach requires the involvement of the individual and the community in efforts to improve their own health status through increased awareness and participation. As this necessitates changes in behaviour and in the environment, it is essential that the community itself identifies the need for change, and is involved in the process. The training of Community Health Workers is one way of achieving this.

3. BACKGROUND

Within the Afghan Refugee Villages, women and children make up 76% of the population, and are the most vulnerable group, restricted by purdah and an exceptionally low literacy rate. Many women do not utilise the services provided, and the high infant and maternal mortality rates, 87 per 1,000 live births (CDC 1986) and 1176 per 100,000 deliveries (CDC 1984) respectively, indicate the need for improved services for these groups in particular. In order to reach the women and children, it is necessary to extend the health services to within the family homes, and to involve the family members in their own health promotion.

In 1980 Save The Children Fund(UK) established two Basic Health Units in Badaber Refugee Village, Peshawar, to provide

APPENDIX 5.

CONTENTS OF TEACHING AID KIT

1.	Trunk	1
2.	Cotton bag	1
3.	Lock	1
4.	Ball	1
5.	Bar of soap	1
6.	Soap dish	1
7.	Dexie	1
8.	Cotton thread	1
9.	Cotton wool	1
10.	Glass	1
11.	Metal spoon	1
12.	Jug	1
13.	Lota plastic (water container)	1
14.	Washing basin (silver)	1
15.	Feeding bottle	1
16.	Jar for sugar	1
17.	Jar for salt	1
18.	Tea cup	1
19.	Plastic container	1
20.	Razor blades	2
21.	Nail brush	1
22.	Red dye	1
23.	Plastic bowls very small	2
24.	Plastic sheet 1 m	1
25.	Cloth poster	1
26.	Fetus	1
27.	Doll	1
28.	Placenta with cord	1
29.	Soft uterus	1
30.	Delivery box	1
31.	Medium pieces of cloth for mother	3
32.	Large pieces of cloth for baby	3
33.	Very small pieces of cloth to clean baby's, eye, ear, mouth and nose.	4
34.	Sugar	300 g
35.	Salt	150 g

COST OF KIT (1989) Rs. 1,400.00

APPENDIX 6.

CONTENTS OF FHW KIT

1.	Small tin trunk	1
2.	Nail brush	1
3.	Soap	1
4.	Soap container	1
5.	Roll of cotton thread	1
6.	Plastic container	1
7.	Cotton wool	1
8.	Razor blades	2
9.	Cotton bag	1
10.	Small dexie	1
11.	Glass	1
12.	Jar for sugar	1
13.	Jar for salt	1
14.	Sugar	300 g
15.	Salt	150 g
16.	Tea-spoon	1
17.	Small cup	1
18.	Small pieces of cloth to clean babies eyes, mouth, nose, ears.	4
19.	Small plastic bowls	2
20.	Plastic sheet 1 m	1
21.	Lock	1

COST OF KIT 1989. Rs. 380.00

health services for approximately 30,000 refugees.

In 1983 the Primary Health Care programme was introduced. Afghan males, selected by their communities, were trained as Community Health Workers (CHWs) and Community Health Supervisers (CHSs). It was appreciated that the Male Programme would not be able to reach all the women in the villages, but due to political and cultural sensitivities, it was necessary to gain the support and trust of the male population before a Female Training Programme could be introduced.

4. DEVELOPMENT OF THE FEMALE PROGRAMME

4.i PROGRESS SUMMARY

1984 - Training of Dais (Traditional Birth Attendants) in Badaber Refugee Village. Introduction of a Dai Training Programme to one camp in Dir District.

1985 - Expansion of the Dai Training Programme to 3 camps in Dir District.

1986 - Evaluation of the Dai Training Programme by an external Consultancy Team. Expansion recommended. Proposal for the Female Health Worker programme submitted to UNICEF.

1987 - Funding for the programme confirmed. Recruitment of female staff and training of Training Team.

Baseline surveys performed.

Training of Female Health Workers commenced in Bajaur Agency.

1988 - Programme expanded to Bajaur and Kurrum Agencies, Kohat and Dir Districts.

4.ii THE TRADITIONAL BIRTH ATTENDANT (DAI)

The original Dai Training Programme was designed to upgrade the knowledge and skills of already existing Traditional Birth Attendants (Dais) in the Refugee Villages. Although in Afghanistan the traditional Dai was active within her village, in the refugee situation her role has been restricted. The village communities of Afghanistan have been

dispersed throughout the refugee "villages" in Pakistan. These "villages" now consist of many different tribal and political groups.

Many Dais can only visit those families in their villages who are related, or are grouped through a mutual malik or leader. The increased influence of fundamentalist Islam following the revolution in Afghanistan has led to the stricter observance of purdah and a deep suspicion of training programmes, particularly of those for women.

Due to this suspicion and the strict purdah, it has been very difficult to identify the traditional Dais within the refugee villages. The men do not want their women to visit outside their immediate family group, and the women themselves are reluctant to visit. Deliveries are performed by female relatives in the home. This has led to many women being involved in deliveries, but very few with much experience.

As the Dai in Afghanistan was traditionally only called for childbirth and emergencies, it was decided to change the title from Dai to Female Health Worker(FHW), with a view to expanding their role to cover health education and the prevention of disease.

4.iii MATERNAL AND CHILD HEALTH SERVICES

Health services for Afghan Refugees are provided by the Government of Pakistan through the Project Directorate of Health(PDH). This Directorate covers both the preventive and curative aspects of health care. The Maternal and Child Health(MCH) programme is supervised by the Deputy Director(MCH), assisted by two Lady Health Visitor Supervisors.

In the Afghan Refugee Villages, health services are provided through a Basic Health Unit (BHU) per 15,000 population. These BHUs are staffed by a minimum of 8 persons, including a Medical Officer(MO) and Lady Health Visitor(LHV).

In the Basic Health Unit, the LHV is required to provide curative care for women as well as her duties in the MCH programme. The heavy demand for curative services often interferes with preventative activities. There is also a shortage of LHVs in the province and many BHUs are without their services, or have to share an LHV with another Unit.

4.iv THE FEMALE HEALTH WORKER PROGRAMME

The aim of the FHW programme is to train women, selected by their communities throughout the refugee villages, in basic maternal and child care. These women are responsible for the women and children within their own family groups, and for the referral of any complications or problems to the BHUs.

As many of these women(FHWs) are not allowed to visit the BHU unless ill or accompanied by a male relative, it is necessary to identify one or two women per village to act as the link between the FHWs and the BHU. These women are called Female Health Supervisors (FHS).

The FHSs are paid a small salary (Rs.500 per month) for part time duties at the BHU:

- to assist the LHV in the mother and child care programme.
- to provide feedback of information to and from the FHWs.
- to ensure integration of the FHW programme within the health services.
  (For Role of FHS & FHW see Appendix 1 and 2.)

SCF is responsible for the identification and training of the FHSs and FHWs in each village. As the FHSs and FHWs are an integral part of the MCH services, their follow up, support and supervision once trained is most appropriately carried out by the LHV in the BHU. Close co-operation, liaison and feedback of information between SCF and the PDH is essential for an effective programme.
(For organogram - see Appendix 3)

5. <u>THE TRAINERS</u>

5.i RECRUITMENT OF TRAINERS

The training of FHWs must be carried out by females. The original intention was that the Female Training Team would train the FHSs in the Refugee Villages and the FHSs would then select and train the FHWs, supervised by the SCF Training Team, as was the method in the Male Programme. This proved to be unrealistic, due to the limited exposure to education and the lack of teaching skills of the majority of Afghan women in the villages. It is therefore necessary for the Training Team to train both FHSs and FHWs themselves.

It was hoped to recruit Afghan women to form the Training Team. However it proved very difficult to find Afghans who could travel and live in the field during the week, even when all facilities were provided. Pakistani LHVs were recruited, and proved to be very successful trainers, as many had previous experience in Dai training, or had worked in BHUs in the refugee villages. In 1989 Afghan women who are willing to live in the field have come to Pakistan, and it appears that this problem has lessened.

5.ii CRITERIA FOR SELECTION OF TRAINERS

It is not essential that trainers are LHVs, but a previous knowledge of health care, particularly concerning delivery, is helpful. This enables them to answer the more specific questions asked by the FHWs during training. However, motivated women with previous educational experience and good comunication skills can be trained to be effective teachers.

Older women who have had children are preferable, as they are respected by the male community and the women under training. Women with young children are often unable to travel and live in the field.

It is important that the trainers are sensitive to the Afghan code of behaviour and have an understanding of the problems faced by the refugees. To be accepted by the refugee community it is essential that the trainers are sensible, well behaved, and suitably dressed. Even rumours of members of the Training Team behaving inappropriately can jeopardise the entire programme. This has to be explained to candidates during the selection interviews.

In view of the shortage of LHVs and women suitable as trainers, it is best if agencies pay comparable salaries, to avoid competition for staff between programmes which have the same aims. SCF makes a point of requiring candidates working with other agencies to provide a "No objection" certificate from their existing employer before being recruited.

5.iii TRAINING OF TRAINERS

The Training of the Female Trainers consists of a minimum of 3 weeks in the classroom, followed by one month as observers in the field training programmes. After this they assist in

courses for one month before they start their own training group under supervison. The contents of their training course include:

- Introduction to Primary Health Care.
- Motivation Techniques.
- Selection Procedures.
- Study of Training Manual (see Appendix 4 for topics.)
- Teaching Methodologies and Practice.
- Evaluation techniques.

Despite an intensive initial training, ongoing inservice training is essential in the form of regular workshops and seminars. This not only develops the trainers skills, but also motivates them to implement their new ideas in the training sessions.

6. MOTIVATION FOR THE FHW PROGRAMME

6.i ADMINISTRATIVE AUTHORITIES

Before introducing the programme to a new area, it is necessary to visit the administrative authorities. The programme must be explained to the District/Agency Administrator, the Area Administrator and the Refugee Village Administrator. It is important that they are fully informed about the programme. Their support can sometimes overcome difficulties amongst the village leaders and they can also provide information on the tribal groupings and the geographical layout of the village.

6.ii HEALTH SERVICES

The Field Supervising Medical Officer is responsible for all health services at District/Agency level. His support is essential to ensure cooperation from the BHU staff.

The programme must be fully explained to all BHU staff, and the MO and LHV in particular. The LHVs are often anxious that supervision of the programme will increase their already heavy workload. The roles of the FHS and FHWs and the ways in which they can assist the LHV in her duties, must be explained.

6.iii THE COMMUNITY

The next step is to gain the permission and approval for the programme from the male elders of the refugee village. The senior Maliks and elders must be approached initially, as without their support the programme will not be allowed to continue. Once permission has been given, the male elders play a lesser role in the FHW programme, unless they are asked to assist with problems.

During motivation it is explained to the elders that one woman is to be proposed for training from each extended family group. This is necessary in order to cover the total female population, within the constraints of the strict observance of purdah. However, as there is only one LHV in each BHU she can only adequately supervise a limited number of FHWs - approximately 30. This number may be increased in villages where the LHV is active and capable of supervising more FHWs.

If members of the same extended family group are trained, other families will not benefit from the programme. When relying on a malik's list of women for training, there may be a large number of women from his own extended family. This occurs less frequently when using an established network of CHSs and CHWs.

In villages with large populations, total coverage may not be possible, as the LHV cannot effectively supervise the required number of FHWs. Coverage rates depend upon a number of factors:

- the ability of the LHV.
- the geographical spread of the refugee village.
- the tribal groupings within the village.
- the degree of purdah observed.

In areas where the village is spread over many kilometres and no transport is available for the LHV, supervision of the FHWs is difficult. Where there are many different tribes in a village, more FHSs and FHWs will need to be trained. This may also reduce the number of families each FHW is able to cover.

It is important to understand and accept the need for flexibility in the numbers of families covered by FHWs and the number of FHWs trained. Every village must be taken

individually, with the aim to achieve the greatest coverage possible within that situation.

The number of FHSs selected also depends on the tribal groupings and geographical spread of the village. This will in turn determine the number of FHWs one FHS is responsible for. However, every FHW must be responsible to a FHS as her link with the BHU.

The refugee community are extremely wary of education for women, and some will even quote female education programmes as one of the reasons they left their homes in Afghanistan. It is very important not to push the elders for a quick decision. This may lead to a refusal, which once given will not easily be retracted. Discussions should always be left open to be continued in the future.

There is a fear to speak out in favour of a training programme for women, and group pressure should not be under estimated. Visits to individual elders are advisable before calling a large Jirga - a meeting of elders.

A male Afghan may sometimes have more success in convincing the elders of the benefits of the programme if difficulties have been encountered. If male Community Health Workers and Supervisors are present in the village, they are most effective in influencing their own community.

Many meetings may be necessary before the community are convinced of the need for FHW training. However this is essential for a successful programme. The elders, or CHSs if available, are then requested to submit a list of names of women who meet the necessary criteria and are interested in being trained.

7. IDENTIFICATION OF WOMEN

Having motivated the male community, it is necessary to meet the women who have been proposed for training. Sometimes their names have been put forward without their consent. These women are often frightened that the training will be too difficult and will involve too much time and work. The Female Trainers and the LHV from the BHU must meet the women and ensure that the programme is fully understood, and that the women want to be trained.

7.i SELECTION OF FHWS

FHWs are selected by their own extended family group. However, certain criteria are recommended for selection.

- The women should be between 25 and 45 years, and experienced Dais if possible.
- Preferably they should be married and have had children, as this gives them more standing in the community.
- Widows are often selected as they are mobile, active and keen to take on extra duties.
- They must be respected by and acceptable to their extended families, and willing to be trained and to work as a volunteer FHW.
- They must be resident in the refugee village.

7.ii SELECTION OF FHSs

The position of FHS is highly coveted by the maliks, CHSs and the women themselves, due to the part time salary.

The FHS is trained with the FHWs, and for this reason it is important that she is selected either before or within the first two weeks of the training programme. This will enable her to establish herself as their supervisor. The FHS is selected following discussions between the Senior Trainer, the LHV and the FHWs. An expatriate is usually involved in the decision, as this helps to exclude accusations of bias and bribes. It is very important that the FHS is acceptable to the FHWs and that she has a good working relationship with them and the LHV in the BHU.

It is accepted that selection of the FHS before training commences runs the risk of choosing a woman who may be less capable on the course than the other FHWs. This may cause her to lose her respect and credibility. It is important to give her extra responsibilities during the course, such as care of the teaching aids and organisation of home visits, in order to build-up her confidence and to elevate her position. However, if the selection is left until later in the training, the competition for the position intensifies. In this situation disappointed FHWs have refused to accept the selected FHS and to work as FHWs. Aggressive competition should not be underestimated. Conversely, at times the women select the poorest woman out of sympathy for her situation.

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THE TRAINING OF FEMALE HEALTH WORKERS IN AFGHAN REFUGEE VILLAGES IN N.W.F.P. PAKISTAN



SOPHY FORMAN
CATHERINE LIDWILL
SAVE THE CHILDREN FUND(UK)
OCTOBER, 1989

C O N T E N T S